



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SAN ANTONIO SPINE AND REHAB  
1313 SE MILITARY RD STE 107  
SAN ANTONIO TX 78214

#### **Respondent Name**

INDEMNITY INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 15

#### **MFDR Tracking Number**

M4-11-4510-02

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The insurance is denying future treatment based on a peer review. The RME on file was done in 2009 therefore the patient's recent medical information has not been reviewed. The insurance carrier cannot prospectively deny future care. Per the ODG guidelines office visits are 'recommended as determined to be medically necessary...'"

**Amount in Dispute:** \$175.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a position summary with their response to the request for medical dispute resolution.

**Response Submitted by:** Gallaher Bassett, 6406 Intl Pkwy, Ste. 2300, Plano, TX 75093

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2010	CPT Code 99213	\$175.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).

4. This request for medical fee dispute resolution was received by the Division on August 04, 2011
5. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated April 16, 2011 and September 24, 2010
  - 219 – Based on extent of injury
  - 215 – Based on the findings of the review organization.

### **Issues**

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

### **Findings**

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The office visit of September 7, 2010 was initially denied as not medically necessary based on the findings of the review organization. On April 16, 2011 the reconsideration for services rendered to the injured employee was denied based on an extent of injury. The respondent submitted a copy of the decision and order from a Contested Case Hearing held on May 19, 2011. According to the decision and order the Claimant has been diagnosed with lumbar radiculopathy, L2/L3, L3/L4, and L5/S1 herniated nucleus pulposus (HNP) with a segmental instability at L2/L3. The L2/L3 herniated nucleus pulposus (HNP) and segmental instability at L2/L3 arose out of or naturally flowed from the compensable injury. The lumbar radiculopathy and the L3/L4, and L4/S1 herniated nucleus pulposus (HNP) did not arise out of or naturally flow from the compensable injury. The decision of the Contested Case Hearing is that the compensable injury of May 13, 2008, extends to include L2/L3 herniated nucleus pulposus (HNP) with segmental instability at L2/L3. The compensable injury of May 13, 2008, does not extend to include lumbar radiculopathy, and L3/L4, and L5/S1 herniated nucleus pulposus (HNP).
3. The reconsideration denial, which denied the office visit for not medically necessary based on the findings of a review organization has not been resolved in accordance with 28 Texas Administrative Code §133.305(a)(4) and is not eligible for review.
4. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

### **Conclusion**

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	_____	May 23, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**